

**Alabama Medicaid Agency  
Pharmacy and Therapeutics Committee**

**Date of Meeting: Wednesday May 12 2010  
Preferred Drug List Final**

**AHFS Drug Class Reviewed: FIRST GENERATION ANTIHISTAMINES**

**AHFS Drug Class Re-reviewed: ESTROGENS**

**AHFS Drug Class Re-reviewed: ANTIDIABETIC AGENTS**

**Subclasses Reviewed**

**Alpha-Glucosidase Inhibitors**

**Amylinomimetics**

**Biguanides**

**Dipeptidyl Peptidase-4 (DPP-4) Inhibitors**

**Incretin Mimetics**

**Insulins**

**Meglitinides**

**Sulfonylureas**

**Thiazolidinediones**

## First Generation Antihistamines

<u>PREFERRED GENERIC/OTC</u>	<u>PREFERRED BRAND</u>	<u>NON-PREFERRED BRAND or PA GENERIC</u>
All covered products	NONE	ACCUHIST* AHIST ALDEX-AN ALDEX CT ALDEX D ALERSULE* BROMAX BROMFED* BROMFED-PD* BROVEX ADT BROVEX PD BROVEX PSE DALLERGY* DECONSAL CT DURATUSS DA DYTUSS HISTEX* HISTEX SR J-TAN D PD* J-TAN PD* LODRANE* LODRANE 24 LODRANE 24D LODRANE D MYCI CHLOR-TAN* MYCI CHLORPED* MYCI CHLORPED D* NALEX-A* NASOHIST* PALGIC* PEDIATEX TD* PHENA-PLUS PHENA-S* PHENA-S 12 POLY HIST PD* RESCON-JR* RESCON-MX SR RESPAHIST-II* RYNA-12 RYNA-12 S*

\*Denotes generic available in at least one dosage form or strength  
 Drug name denotes all dosage forms and strengths unless noted

## First Generation Antihistamines (Cont'd)

<u>PREFERRED GENERIC/OTC</u>	<u>PREFERRED BRAND</u>	<u>NON-PREFERRED BRAND or PA GENERIC</u>
All covered products	NONE	RYNATAN* RYNATAN PEDIATRIC* RYNESA 12S* SUDAL-12 TEKRAL TIBAMINE LA* TRIPOHIST* TRIPOHIST D TUSSANIL VAZOBID* VAZOL* VAZOTAB VIRAVAN-P ZOTEX-PE*

\*Denotes generic available in at least one dosage form or strength  
 Drug name denotes all dosage forms and strengths unless noted

## Estrogens

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

CENESTIN  
MENEST  
PREMARIN (TABLET)

### NON-PREFERRED BRAND or PA GENERIC

ACTIVELLA\*  
ALORA  
ANGELIQ  
CLIMARA\*  
CLIMARA PRO  
COMBIPATCH  
DELESTROGEN\*  
DEPO-ESTRADIOL  
DIVIGEL  
ELESTRIN  
ENJUVIA  
ESTRACE\*  
ESTRADERM  
ESTRASORB  
ESTRING  
EVAMIST  
FEMHRT  
FEMRING  
FEMTRACE  
MENOSTAR  
OGEN\*  
PREFEST  
PREMARIN (CREAM)  
PREMPHASE  
PREMPRO  
VAGIFEM  
VIVELLE-DOT

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## Alpha-Glucosidase Inhibitors

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

GLYSET

### NON-PREFERRED BRAND or PA GENERIC

PRECOSE\*

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Drug name denotes all dosage forms and strengths unless noted

## Amylinomimetics

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

NONE

### NON-PREFERRED BRAND or PA GENERIC

SYMLIN

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Drug name denotes all dosage forms and strengths unless noted

## Biguanides

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

NONE

### NON-PREFERRED BRAND or PA GENERIC

FORTAMET  
GLUCOPHAGE\*  
GLUCOPHAGE XR\*  
GLUMETZA  
RIOMET

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Drug name denotes all dosage forms and strengths unless noted

## Dipeptidyl Peptidase-4 (DPP-4) Inhibitors

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

NONE

### NON-PREFERRED BRAND or PA GENERIC

JANUVIA  
JANUMET  
ONGLYZA

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Drug name denotes all dosage forms and strengths unless noted



## Incretin Mimetics

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

NONE

### NON-PREFERRED BRAND or PA GENERIC

BYETTA  
VICTOZA

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Drug name denotes all dosage forms and strengths unless noted

## Insulins

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

HUMALOG  
LANTUS  
LEVEMIR

### NON-PREFERRED BRAND or PA GENERIC

APIDRA  
HUMALOG MIX 50/50  
HUMALOG MIX 75/25  
HUMULIN R (U-500)  
NOVOLOG  
NOVOLOG MIX 70/30

\*Denotes generic available in at least one dosage form or strength  
Drug name denotes all dosage forms and strengths unless noted

## Meglitinides

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

PRANDIN

### NON-PREFERRED BRAND or PA GENERIC

PRANDIMET  
STARLIX\*

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## Sulfonylureas

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

NONE

### NON-PREFERRED BRAND or PA GENERIC

AMARYL\*  
DIABETA\*  
GLUCOTROL\*  
GLUCOTROL XL\*  
GLUCOVANCE\*  
GLYNASE\*  
METAGLIP\*

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## Thiazolidinediones

### PREFERRED GENERIC/OTC

All covered products

### PREFERRED BRAND

ACTOPLUS MET  
ACTOS  
AVANDAMET  
AVANDARYL  
AVANDIA

### NON-PREFERRED BRAND or PA GENERIC

DUETACT

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